PRIOR AUTHORIZATION CRITERIA

DRUG CLASS **NUTRITIONAL SUPPLEMENTS – INBORN ERRORS OF METABOLISM**

Status: Client Requested Criteria
Type: Initial Prior Authorization ***Ref # C1411-A***

CRITERIA FOR APPROVAL

1. Is this product medically necessary due to inborn errors of metabolism including inherited diseases of amino acids and organic acids? Yes No

Guidelines for Approval	
Duration of Approval	**Lifetime**
Set 1	
Yes to question(s)	**No to question(s)**
1	None

RATIONALE
Client Requested

The client has chosen to cover nutritional supplements for inborn errors of metabolism with prior authorization when the product is medically necessary due to inborn errors of metabolism including inherited diseases of amino acids and organic acids.

REFERENCES
N/A

Written by: UM Development (RP)
Date Written: 03/2013
Revised:
Reviewed: Medical Affairs (KP) 03/2013

The Participating Group signed below hereby accepts and adopts as its own the criteria for use with Prior Authorization, as administered by CVS Caremark.

_____ _____
Signature Date

_____
Client Name